BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

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| In the matter of the adoption of New Rules I through XXVIII pertaining to home and community-based services for adults with severe disabling mental illness | ) ) ) ) ) | NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION |

TO: All Interested Persons

1. On September 13, 2006, at 11:00 a.m., a public hearing will be held in Room 207 of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed adoption of the above-stated rules.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who need an alternative accessible format of this notice or provide reasonable accommodations at the public hearing site. If you need to request an accommodation, contact the department no later than 5:00 p.m. on September 5, 2006, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970; e-mail dphhslegal@mt.gov.

2. The rules as proposed to be adopted provide as follows:

RULE I. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: FEDERAL AUTHORIZATION AND STATE ADMINISTRATION (1) The U.S. Department of Health and Human Services (HHS) has granted the department, under 42 CFS 441.300 through 441.310, the authority to establish a program of Medicaid funded home and community-based services for persons who have severe disabling mental illness, as defined in ARM 37.89.103, and who would otherwise have to reside in and receive Medicaid reimbursed care in a nursing facility or a hospital.

(2) The department, in accordance with the state and federal statutes and the rules generally governing the provision of Medicaid funded home and community-based services, any federal-state agreements specifically governing the provision of the Medicaid funded home and community-based services to be delivered under this program, and within the available funding appropriated for the program, may determine within its discretion:

(a) the types of services to be available through the program;

(b) the amount, scope, and duration of the services available through the program;

(c) the categories of persons to be served through the program;

(d) the total number of persons who may receive services through the

program;

(e) the total number of persons who may receive services through the program by category of eligibility, geographical area, or specific case management team; and

(f) eligibility of individual persons for the program.

(3) Enrollment in the program and the provision of services through the program are at the discretion of the department. There is no legal entitlement to enroll in the program or to receive any or all the services available through the program.

(4) The state has received federal approval to waive statewide coverage in the provision of program services. Program services may only be delivered to recipients in the following service areas for which federal approval of coverage has been received:

(a) Yellowstone County Region, inclusive of the counties of Yellowstone, Big Horn, Carbon, Stillwater, and Sweet Grass;

(b) Cascade County Region, inclusive of the counties of Cascade, Blaine, Chouteau, Glacier, Hill, Liberty, Pondera, Teton, and Toole; and

(c) Butte-Silver Bow County Region, inclusive of the counties of Butte-Silver Bow, Beaverhead, Deer Lodge, Granite, and Powell.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE II. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: THE PROVISION OF SERVICES

(1) The services available through the program are limited to those specified in this rule.

(2) The department may determine the particular services of the program to make available to a recipient based on, but not limited to, the following criteria:

(a) the recipient's need for a service generally and specifically;

(b) the availability of a specific service through the program and any ancillary service necessary to meet the recipient's needs;

(c) the availability otherwise of alternative public and private resources and services to meet the recipient's need for the service;

(d) the recipient's risk of significant harm or of death if not in receipt of the service;

(e) the likelihood of placement into a more restrictive setting if not in receipt of the service; and

(f) the financial costs for and other impacts on the program arising out of the delivery of the service to the person.

(3) A person enrolled in the program may be denied a particular service available through the program that the person desires to receive or is currently receiving.

(4) Bases for denying a service to a person include, but are not limited to:

(a) the person requires more supervision than the service can provide;

(b) the person's needs, inclusive of health, cannot be effectively or appropriately met by the service;

(c) access to the service, even with reasonable accommodation, is precluded by the person's health or other circumstances;

(d) a necessary ancillary service is no longer available; or

(e) the financial costs for and other impacts on the program arising out of the delivery of the service to the person.

(5) The following services, as defined in these rules, may be provided through the program:

(a) case management services;

(b) homemaking;

(c) personal assistance;

(d) adult day health;

(e) habilitation;

(f) respite care;

(g) personal emergency response systems;

(h) nutrition services;

(i) nonmedical transportation;

(j) outpatient occupational therapy;

(k) nursing;

(l) psycho-social consultation;

(m) dietetic services;

(n) adult residential care;

(o) specially trained attendant care;

(p) chemical dependency counseling;

(q) specialized medical equipment and supplies;

(r) supported living;

(s) illness management and recovery services; and

(t) Wellness Recovery Action Plan (WRAP) services.

(6) Monies available through the program may not be expended on the following:

(a) room and board; and

(b) special education and related services as defined at 20 USC 1401(16) and (17).

(7) A program service is not available to a recipient if that type of service is otherwise available to the recipient from another source.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE III. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: PROVIDER REQUIREMENTS

(1) Services of the program may only be provided by or through a provider that:

(a) is enrolled with the department as a Medicaid provider or, if not an enrolled Medicaid provider, is under contract with a Medicaid provider that the department is contracting with for home and community-based case management services and that the department has authorized to reimburse non-Medicaid providers;

(b) meets all the requirements necessary for the receipt of Medicaid monies;

(c) has been determined by the department to be qualified to provide services to adults with severe disabling mental illness;

(d) is a legal entity;

(e) is appropriately insured as determined by the department; and

(f) meets all facility and other licensing requirements applicable to the services offered, the service settings provided, and the professionals employed.

(2) A recipient's immediate family members may not provide services to the recipient as a reimbursed provider or as an employee of a reimbursed provider. Immediate family members include a spouse or legal guardian.

(3) A provider may also provide support to other family members in the recipient's household during hours of program reimbursed service if approved by the case management team.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE IV. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: ELIGIBILITY AND SELECTION

(1) The department may consider for eligibility in and may enroll in the program persons who the department determines qualify for enrollment in accordance with the criteria in [RULE IV].

(2) In order to be considered by the department for eligibility in the program, a person must be determined to qualify for enrollment in accordance with the criteria in this rule.

(3) A person is qualified to be considered for enrollment in the program if the person meets the following criteria:

(a) is 18 years of age or older or is certified as disabled by the Social Security Administration;

(b) is Medicaid eligible;

(c) requires the level of care of a nursing facility as determined in accordance with the preadmission screening provided for in ARM 37.40.202, 37.40.205, and 37.40.206;

(d) does not currently reside in a hospital or a nursing facility;

(e) has needs that can be met through the program;

(f) meets the severe disabling mental illness definition at ARM 37.89.103; and

(g) resides in one of the following service areas for which federal approval of coverage has been received:

(i) Yellowstone County Region, inclusive of the counties of Yellowstone, Big Horn, Carbon, Stillwater, and Sweet Grass;

(ii) Cascade County Region, inclusive of the counties of Cascade, Blaine, Chouteau, Glacier, Hill, Liberty, Pondera, Teton, and Toole; and

(iii) Butte-Silver Bow County Region, inclusive of the counties of Butte-Silver Bow, Beaverhead, Deer Lodge, Granite, and Powell.

(4) The department may consider for an available opening for program services a person who, as determined by the department:

(a) meets the criteria of [RULE IV];
(b) is actively seeking services;
(c) is in need of the services available;
(d) is likely to benefit from the available services; and
(e) has a projected total cost of plan of care that is within the limits specified in [RULE VII].

(5) The department offers an available opening for program services to the applicant, as determined by the department, who is:
(a) most in need of the available services;
(b) most likely to benefit from the available services; and
(c) whose projected total cost plan of care is within the applicable limits specified in [RULE VII].

(6) Factors to be considered in the determination of whether a person is:
(a) in need of the available program services;
(b) likely to benefit from those services; and
(c) which person is most likely to benefit from the available services include, but are not limited to, the following:
(i) medical condition;
(ii) degree of independent mobility;
(iii) ability to be alone for extended periods of time;
(iv) presence of problems with judgment;
(v) presence of a cognitive impairment;
(vi) prior enrollment in the program;
(vii) current institutionalization or risk of institutionalization;
(viii) risk of physical or mental deterioration or death;
(ix) willingness to live alone;
(x) adequacy of housing;
(xi) need for adaptive aids;
(xii) need for 24 hour supervision;
(xiii) need of person’s caregiver for relief;
(xiv) appropriateness for the person, given the person’s current needs and risks, of services available through the program;
(xv) status of current services being purchased otherwise for the person; and
(xvi) status of support from family, friends, and community.

(7) A recipient may be removed from the program by the department. Bases for removal from the program include, but are not limited to the following:
(a) a determination by the case management team that the services, as provided for in the plan of care, are no longer appropriate or effective in relation to the person’s needs;
(b) the failure of the person to use the services as provided for in the plan of care;
(c) the behaviors of the person place the person, the person's caregivers, or others at serious risk of harm or substantially impede the delivery of services as provided for in the plan of care;
(d) the health of the person is deteriorating or in some other manner placing the person at serious risk of harm;
(e) a determination by the case management team that the service providers

necessary for the delivery of services to the person, as provided for in the plan of care, are unavailable;

(f) a determination that the total cost of the person's plan of care is not within the limits specified at [RULE VII];

(g) the person no longer requires the level of care of a nursing facility as determined in accordance with the preadmission screening provided for in ARM 37.40.202, 37.40.205, and 37.40.206; and

(h) the person no longer resides in one of the counties specified in [RULE IV].

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE V. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: REIMBURSEMENT (1) Services available through the program are reimbursed as provided in this rule.

(2) The following services are reimbursed as provided in (3):

(a) homemaking;

(b) adult day health;

(c) habilitation;

(d) personal emergency response systems;

(e) nutrition;

(f) psycho-social consultation;

(g) nursing;

(h) dietetic services;

(i) specially trained attendant care;

(j) chemical dependency counseling;

(k) supported living;

(l) adult residential care;

(m) respite care not provided by a nursing facility;

(n) nonmedical transportation;

(o) specialized medical equipment and supplies;

(p) illness management and recovery services; and

(q) Wellness Recovery Action Plan (WRAP).

(3) The services specified in (2) are, except as otherwise provided in (4), reimbursed at the lower of the following:

(a) the provider's usual and customary charge for the service; or

(b) the rate negotiated with the provider by the case management team up to the department's maximum allowable fee.

(4) The services specified in (2) are reimbursed as provided in (3) except that reimbursement for components of those services that are incorporated by specific cross reference from the general Medicaid Program may only be reimbursed in accordance with the reimbursement methodology applicable to the component service of the general Medicaid Program.

(5) The following services are reimbursed in accordance with the referenced provisions governing reimbursement of those services through the general Medicaid Program:

(a) personal assistance as provided at ARM 37.40.1105; and

(b) outpatient occupational therapy as provided at ARM 37.86.610.

(6) Case management services are reimbursed, as established by contractual terms, on either a per diem or hourly rate.

(7) Respite care services provided by a nursing facility are reimbursed at the rate established for the facility in accordance with ARM Title 37, chapter 40, subchapter 3.

(8) Reimbursement will not be paid for a service that is otherwise available from another source.

(9) No copayment is imposed on services provided through the program but recipients are responsible for copayment on other services reimbursed with Medicaid monies.

(10) Reimbursement is not available for the provision of services to other members of a recipient's household or family unless specifically provided for in these rules.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE VI. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: PLANS OF CARE (1) A plan of care is a written plan of supports and interventions based on an assessment of the status and needs of a recipient. The plan of care describes the needs of the recipient and the services available through the program and otherwise that are to be made available to the recipient in order to maintain the recipient at home and in the community.

(2) The services that a recipient may receive through the program and the amount, scope, and duration of those services must be specifically authorized in writing through an individual plan of care for the person.

(3) The plan of care is initially developed upon the person's entry into the program. The plan must be reviewed and, if necessary, revised at intervals of at least six months beginning with the date of the initial plan of care.

(4) Each plan of care is developed, reviewed, and revised by the case management team.

(5) The case management team, in developing the plan of care, consults with the recipient or the recipient's legal representative, with treating and other appropriate health care professionals, and others who have knowledge of the recipient's needs.

(6) Each plan of care must include the following:

(a) diagnosis, symptoms, complaints, and complications indicating the need for services;

(b) a description of the recipient's functional level;

(c) objectives;

(d) any orders for:

(i) medication;

(ii) treatments;

(iii) restorative and rehabilitative services;

(iv) activities;

(v) therapies;

(vi) social services;

(vii) diet; and

(viii) other special procedures recommended for the health and safety of the recipient to meet the objectives of the plan of care;

(e) the specific program and other services to be provided, the frequency of the services, and the type of provider to provide them;

(f) the projected annualized costs of each program service; and

(g) names and signatures of all persons who have participated in developing the plan of care (including the recipient, unless the recipient's inability to participate is documented) which will verify participation, agreement with the plan of care, and acknowledgement of the confidential nature of the information presented and discussed.

(7) Inclusion of the need for and the identification of nonprogram services in the plan of care does not financially obligate the department to fund those services or to assure their delivery and quality.

(8) The case management team must provide a copy of the plan to the recipient.

(9) Plan of care approval is based on:

(a) completeness of plan;

(b) consistency of plan with the needs of the person; and

(c) feasibility of service provision, including cost-effectiveness of plan as provided for in [RULE VII]; and

(d) the conformance of the plan with [RULE I through IX].

(10) In accordance with ARM 37.85.414, the case management team must keep the plans of care on file and all records must be retained for a period of at least six years and three months from the date on which the service was rendered or until any dispute or litigation concerning the services is resolved, whichever is later.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE VII. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: COST OF PLAN OF CARE (1) In order to maintain the program cost within the appropriate monies of the financial limitations imposed under federal authorities, the cost of plans of care for recipients may be limited by the department collectively and individually.

(2) The total annual cost of services for each recipient, except as provided in (3), may not exceed a maximum amount set by the department based on the number of recipients and the amount of monies available to the program as authorized in appropriation by the legislature.

(3) The total cost of services provided under a plan of care to a recipient may exceed the maximum amount set by the department if authorized by the department based on the department's determination that one or more of the following circumstances is applicable:

(a) the excess service need is short term and only a one time purchase is

necessary;

(b) the excess service need is intensive services of 90 days or less which are necessary to:

(i) resolve a crisis situation which threatens the health and safety of the recipient;

(ii) stabilize the recipient following hospitalization or acute medical episode; or

(iii) prevent institutionalization during the absence of the normal caregiver;

(c) the excess service need is adult residential services; or

(d) the recipient has long term needs that result in the maximum amount being exceeded in minor amounts at various times.

(4) The cost of services to be provided under a plan of care is determined prior to implementation of the proposed plan of care and may be revised as necessary after implementation.

(5) The cost determination for the services provided under a plan of care may be made at any time that there is a significant revision in the plan of care.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE VIII. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: NOTICE AND FAIR HEARING

(1) The department provides written notice to an applicant for and recipient of services when a determination is made by the department concerning:

(a) financial eligibility;

(b) level of care;

(c) feasibility, including cost-effectiveness of services to the recipient; and

(d) termination of recipient's eligibility for the program.

(2) The department provides a recipient of services with notice ten working days before termination of services due to a determination of ineligibility.

(3) A person aggrieved by any adverse final determinations as listed in (1)(a) through (d) or any adverse determinations regarding services in the plan of care may request a fair hearing as provided in ARM 37.5.304, 37.5.307, 37.5.313, 37.5.316, 37.5.318, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334, and 37.5.337.

(4) Fair hearings will be conducted as provided for in ARM 37.5.304, 37.5.307, 37.5.313, 37.5.316, 37.5.318, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334, and 37.5.337.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE IX. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: CASE MANAGEMENT, REQUIREMENTS (1) Case management is the planning for, arranging for, implementation of, and monitoring of the delivery of services available through the program to a recipient.

(2) Case management services include:

(a) developing a plan of care for a recipient;

(b) monitoring and managing a plan of care for a recipient;

(c) establishing relationships and contracting with service providers and community resources;

(d) maximizing a recipient's efficient use of services and community resources such as family members, church members, and friends;

(e) facilitating interaction among people working with a recipient;

(f) prior authorizing the provision of all services; and

(g) managing expenditures.

(3) A case management team must consist of:

(a) a registered nurse currently serving on a case management team serving persons who are recipients through the program of home and community services for the elderly and persons with physical disabilities; and

(b) a social worker currently employed by a licensed mental health center with two consecutive years experience providing case management services to adults with mental illness.

(4) The case management team must:

(a) be a legal entity contractually retained by the department to provide Medicaid funded home and community case management services to persons who are elderly or who have physical disabilities;

(b) function as directed by the department;

(c) assure that services provided to recipients are of appropriate quality and cost effective;

(d) provide case management services to no more than the number of persons specified by the department;

(e) manage expenditures within the allocated monies; and

(f) meet the department's reporting requirements.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE X. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: ADULT RESIDENTIAL CARE, REQUIREMENTS (1) Adult residential care is the provision of supportive services to a recipient residing in an adult foster home, a residential hospice, or a personal care facility.

(2) Adult residential care may include:

(a) personal care services as specified at ARM 37.40.1101(1) through (5);

(b) homemaking as specified at [RULE XVI];

(c) social activities;

(d) recreational activities;

(e) medication oversight; and

(f) assistance in arranging transportation for medical care.

(3) Adult residential care must provide for 24 hour on site response staff to meet scheduled or unpredictable needs of recipients and to provide supervision of recipients for safety and security.

(4) A recipient of adult residential care may not receive the following services

through the program:

(a) personal assistance as specified at [RULE XIII];

(b) homemaking services as specified at [RULE XVI];

(c) respite care as specified at [RULE XVII];

(d) medical alert personal emergency response system as specified at [RULE XXIV]; and

(e) nutrition as specified in [RULE XXII].

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XI. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: SUPPORTED LIVING, REQUIREMENTS (1) Supported living is the provision of supportive services to a recipient residing in an individual residence or in a group living situation.

(2) Supported living services may include:

(a) independent living evaluation;

(b) service coordination;

(c) 24 hour supervision of the person;

(d) health and safety supervision;

(e) homemaking services as specified at [RULE XVI];

(f) habilitation aide as specified at [RULE XIV];

(g) supported employment as specified at [RULE XI];

(h) prevocational training as specified at [RULE XIV];

(i) nonmedical transportation as specified at [RULE XXVI]; and

(j) specially trained attendants as specified at [RULE XV].

(3) An entity providing supported living services must meet the following criteria:

(a) be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) or by the Council on Quality in the areas of integrated living, congregate living, personal, social and community services, community employment services, and work services; and

(b) have two years experience in providing services to persons with mental disabilities.

(4) This service must be prior authorized by the department.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XII. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: ADULT DAY HEALTH, REQUIREMENTS (1) Adult day health is the provision of services to meet the health, social, and habilitation needs of a recipient in settings outside the recipient's place of residence. An entity providing adult day health services must be licensed as an adult day care center as provided at ARM 37.106.301, et seq.

AUTH: 53-2-201, 53-6-402, MCA

IMP: 53-2-401, 53-6-402, MCA

RULE XIII. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: PERSONAL ASSISTANCE, REQUIREMENTS (1) Personal assistance is the provision of an array of personal care and other services to a recipient for the purpose of meeting personal needs in the home and the community.

(2) Personal assistance services include the provision of the following services:

(a) personal care services as specified at ARM 37.40.1101(1) through (5) and 37.40.1301, 37.40.1302, 37.40.1305, 37.40.1306, 37.40.1307, and 37.40.1308;

(b) homemaking services as specified at [RULE XV];

(c) supervision for health and safety reasons; and

(d) nonmedical transportation as specified at [RULE XXVI].

(3) Personal assistance services do not include any skilled services that require professional medical training except as allowed in ARM 37.40.1301, 37.40.1302, 37.40.1305, 37.40.1306, 37.40.1307, and 37.40.1308.

(4) The requirements for the delivery of personal care services specified at ARM 37.40.1101, 37.40.1102, 37.40.1105, 37.40.1106, 37.40.1301, 37.40.1302, 37.40.1305, 37.40.1306, 37.40.1307, 37.40.1308, and 37.40.1315 govern the provision of personal assistance services.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XIV. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: HABILITATION, REQUIREMENTS (1) Habilitation is the provision of intervention services designed for assisting a recipient to acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to reside successfully at home and in the community.

(2) Habilitation services may include:

(a) residential habilitation;

(b) day habilitation;

(c) prevocational services;

(d) supported employment; and

(e) habilitation aide.

(3) Residential habilitation is habilitation provided in a community home for persons with mental disabilities.

(4) Day habilitation is habilitation provided in a day service setting.

(5) Prevocational services are habilitative activities that foster employability for a recipient who is not expected to join the general work force or participate in a transitional sheltered workshop within a year by preparing the recipient for paid or unpaid work. Prevocational services include teaching compliance, attendance, task completion, problem solving, and safety.

(6) Supported employment is intensive ongoing support to assist a recipient who is unlikely to obtain competitive employment in performing work activities in a variety of settings, particularly work sites where nondisabled persons are employed.

Supported employment service includes supervision, training, and other activities needed to sustain paid work by a recipient.

(7) Habilitation aide is the assistance of an aide directed at fostering the recipient's ability to achieve independence in instrumental activities of daily living such as homemaking, personal hygiene, money management, transportation, housing, and use of community resources. Habilitation aide services include conducting an assessment and the provision of training and teaching.

(8) An entity, inclusive of its staff, providing habilitation services must be qualified generally to provide the services and specifically to meet each recipient's defined habilitation needs.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XV. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: SPECIALLY TRAINED ATTENDANT CARE, REQUIREMENTS (1) Specially trained attendant care is the provision of supportive services to a recipient residing in their own residence.

(2) Specially trained attendant care services may include:

(a) personal assistance services as specified at [RULE XIII]; and

(b) personal care services as specified at ARM 37.40.1101(1) through (5) and 37.40.1301, 37.40.1302, 37.40.1305, 37.40.1306, 37.40.1307, and 37.40.1308.

(3) A person providing specially trained attendant care must be an employee of a Medicaid enrolled personal assistance provider, trained in accordance with the department's training requirements by the provider and others to deliver the services that meet the specific needs of the recipient.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XVI. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: HOMEMAKING REQUIREMENTS

(1) Homemaking is the provision of general household activities or chore services to a recipient when the recipient is unable to manage the recipient's home or care for self or others in the home, or when another who is regularly responsible for these responsibilities is absent.

(2) Homemaking may include:

(a) household management services consisting of assistance with those activities necessary for maintaining and operating a home and may include assisting the recipient in finding and relocating into other housing;

(b) social restorative services consisting of assistance which further a recipient's involvement with activities and other persons; and

(c) teaching services consisting of activities which improve a recipient's or family's skills in household management and social functioning.

(3) Homemaking services do not include the provision of personal care as specified at ARM 37.40.1101 and 37.40.1302.

(4) A person providing homemaking services must be:

(a) physically and mentally able to perform the duties required; and
(b) literate and able to follow written orders.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XVII. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: RESPITE CARE, REQUIREMENTS (1) Respite care is the provision of supportive care to a recipient so as to relieve those unpaid persons normally caring for the recipient from that responsibility.

(2) Respite care services may be provided only on a short term basis, such as part of a day, weekends, or vacation periods.

(3) Respite care services may be provided in a recipient's place of residence or through placement in another private residence or other related community setting, a hospital, a nursing facility, or a therapeutic camp.

(4) A person providing respite care services must be:

(a) physically and mentally qualified to provide this service to the recipient; and

(b) aware of emergency assistance systems.

(5) A person who provides respite care services to a recipient may be required by the case management team to have the following when the recipient's needs so warrant:

(a) knowledge of the physical and mental conditions of the recipient;

(b) knowledge of common medications and related conditions of the recipient; and

(c) capability to administer basic first aid.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XVIII. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: OUTPATIENT OCCUPATIONAL THERAPY, REQUIREMENTS (1) Outpatient occupational therapy services may include:

(a) occupational therapy services as specified in ARM 37.86.601; and
(b) services for habilitative or maintenance purposes.

(2) The requirements for the delivery of outpatient occupational therapy services provided at ARM 37.86.601, 37.86.605, 37.86.606, and 37.86.610 govern the provision of outpatient occupational therapy services.

(3) No visit limitation exists for maintenance therapy.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XIX. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: PSYCHO-SOCIAL

CONSULTATION, REQUIREMENTS (1) Psycho-social consultation is consultation with providers and caregivers directly involved with a recipient and the development and monitoring of behavior programs.

(2) Psycho-social consultation services may include those services as specified at ARM 37.88.601 and 37.88.605.

(3) Requirements for the delivery of psychological services as specified at ARM 37.88.601 and 37.88.605 govern the provision of psycho-social consultation.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XX. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: CHEMICAL DEPENDENCY COUNSELING, REQUIREMENTS (1) Chemical dependency counseling is the provision of counseling to a recipient with a substance abuse problem by a certified chemical dependency counselor.

(2) Chemical dependency counseling services may be provided on an individual or group basis.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XXI. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: DIETETIC SERVICES, REQUIRMENTS (1) Dietetic services are the management of a person's nutritional needs.

(2) Dietetic services may include evaluation and monitoring of nutritional status, nutrition counseling, dietetic therapy, dietetic education, and dietetic research necessary for the management of a recipient's nutritional needs.

(3) Dietetic services are limited to recipients whose disease or medical condition is caused by or complicated by diet or nutritional status.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XXII. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: NUTRITION, REQUIREMENTS

(1) Nutrition services are meals, congregate meals, and home delivered meals as specified at ARM 37.41.302 including the Meals on Wheels Program.

(2) The requirements for the delivery of nutrition services as specified at ARM 37.41.306 through 37.41.315 govern the provision of nutrition services.

(3) A full nutritional regimen of three meals a day may not be provided through this service.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XXIII. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: NURSING, REQUIREMENTS

(1) Nursing is the provision of individual and continuous nursing care.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XXIV. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: PERSONAL EMERGENCY RESPONSE SYSTEMS, REQUIREMENTS (1) A personal emergency response system is an electronic device or mechanical system used to summon assistance in an emergency situation.

(2) A personal emergency response system must be connected to a local emergency response unit with the capacity to activate emergency medical personnel.

(3) The provision of a personal emergency response system as a service does not include the purchase, installation, or routine monthly charges of a telephone.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XXV. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES, REQUIREMENTS (1) Specialized medical equipment and supplies is the provision of items of medical equipment and supplies to a recipient for the purpose of maintaining and improving the recipient's ability to reside at home and to function in the community.

(2) The provision of medical equipment and supplies services may include:

(a) the provision of consultation regarding the appropriateness of the equipment or supplies; and

(b) the provision of supplies and care necessary to maintain a service animal.

(3) Specialized medical equipment and supplies must:

(a) be functionally necessary and relate specifically to the recipient's disability;

(b) substantively meet the recipient's needs for accessibility, independence, health, or safety;

(c) be likely to improve the recipient's functional ability or the ability of a caregiver or service provider to maintain the recipient in the recipient's home; and

(d) be the most cost effective item that can meet the needs of the recipient.

(4) Any particular item of medical equipment or supplies, except for an item or supply necessary to maintain a service animal, is limited to a one time purchase unless otherwise authorized by the department in writing.

(5) Specialized medical equipment and supplies services do not include:

(a) items used for leisure and recreational purposes only;

(b) items of clothing;

(c) basic household furniture; or

(d) educational items including computers, software, and books unless such items are purchased in conjunction with an environmental control unit.

(6) A service animal is an animal trained to undertake particular tasks on behalf of a recipient that the recipient cannot perform and that are necessary to meet the recipient's needs for accessibility, independence, health, or safety.

(7) A service animal does not include any of the following:

(a) pets, companion animals, and social therapy animals;

(b) guard dogs, rescue dogs, sled dogs, tracking dogs, or any other animal not specifically designated as a service animal; or

(c) wild, exotic, or any other animals not specifically supplied by a training program on the approved provider list.

(8) Supplies necessary for the performance of a service animal may include, but are not limited to, leashes, harness, backpack, and mobility cart when the supplies are specifically related to the performance of the service animal to meet the specific needs of the recipient. Supplies do not include food to maintain the service animals.

(9) Care necessary to the health and maintenance of a service animal may include, but is not limited to, veterinarian care, transportation for veterinarian care, license, registration, and where the recipient or recipient's primary care giver is unable to perform it, grooming.

(10) Certain items of medical equipment or supplies for short term use, as specified by the department, may be leased or rented instead of purchased.

(11) The department may require a consultation prior to the purchase of certain equipment and supplies.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XXVI. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: NONMEDICAL TRANSPORTATION, REQUIREMENTS (1) Nonmedical transportation is the provision to a recipient of transportation through common carrier or private vehicle for access to social or other nonmedical activities.

(2) Nonmedical transportation services are provided only after volunteer transportation services, or transportation services funded by other programs, have been exhausted.

(3) Nonmedical transportation providers must provide proof of:

(a) a valid Montana driver's license;

(b) adequate automobile insurance; and

(c) assurance of vehicle compliance with all applicable federal, state, and local laws and regulations.

(4) Nonmedical transportation services must be provided by the most cost effective mode.

(5) Nonmedical transportation services are available only for the transport of recipients to and from activities that are included in the individual plan of care.

AUTH: 53-2-201, 53-6-402, MCA

IMP: 53-2-401, 53-6-402, MCA

RULE XXVII. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: ILLNESS MANAGEMENT AND RECOVERY SERVICES, REQUIREMENTS (1) Illness management and recovery program consists of a series of weekly sessions where licensed mental health practitioners provide services consisting of personalized strategies for managing mental illness and achieving personal goals to individuals who have experienced the symptoms of schizophrenia, bipolar disorder, and major depression.

(2) The services may be provided in an individual or group format and generally last between three to six months.

(3) Mental health practitioners work collaboratively with individuals by offering a variety of information, strategies, and skills for use to further their own recovery.

(4) Illness management and recovery has been identified as an evidence-based practice by the Substance Abuse and Mental Health Services Administration.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

RULE XXVIII. HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: WELLNESS RECOVERY ACTION PLAN (WRAP) SERVICES, REQUIREMENTS (1) Wellness Recovery Action Plan (WRAP) is a self-management and recovery system.

(2) WRAP is designed to decrease and prevent intrusive or troubling feelings and behaviors, increase personal empowerment, improve quality of life, and assist individuals in achieving their own life goals.

(3) A person who provides WRAP services to a waiver participant will be required by the case management team to be certified by the Copeland Center.

AUTH: 53-2-201, 53-6-402, MCA
IMP: 53-2-401, 53-6-402, MCA

3. The Department of Public Health and Human Services administers for the State of Montana the joint federal/state Medicaid Program of Health Care Services. The federal government allows the states to provide sets of Medicaid funded services to maintain persons in community integrated residential and service settings as opposed to institutional treatment settings such as nursing facilities. These sets of services are authorized through "home and community waivers", also referred to as "1915c waivers", authorized by the federal Centers for Medicare and Medicaid Services (CMS) through formal plan documents submitted by a state for approval.

In 1980, Montana initiated the first program in the country of home and community services funded with Medicaid monies. That program provided developmental disabilities treatment services in community settings as opposed to an institutional Intermediate Care Facility for the Mentally Retarded (ICF/MF). Montana early on also developed a home and community program to serve persons who are elderly or

who have physical disabilities. That program allows persons to avoid institutionalization in nursing facilities or hospitals. In more recent years that program has expanded to encompass services for persons with brain injuries.

The Montana Legislature in 2005 passed substantive legislation, 2005 Laws of Montana, Chapter 353, and appropriated monies authorizing the department to seek federal approval for a home and community program that would serve adults who have severe disabling mental illness.

The state has determined that among the population of persons with mental illness there are those for whom the severity of their mental illness is so disabling that they are unable to adequately care for themselves and are in need of a nursing facility to maintain their well being, particularly their health. The state will be submitting an application to CMS requesting approval to implement as an alternative to Medicaid funded institutional services a program of less restrictive home and community services to provide for the various health care needs of persons with severe disabling mental illness.

Under the federal authority governing the implementation of home and community services funded with Medicaid monies, each authorized program is to have a service population defined by particular disabilities and certain service needs and is to be limited in number. In addition, a state may limit the services on a geographical basis. These parameters are proposed by a state and approved by CMS. The services in this proposed program that the state is submitting for federal approval are generally not available as Medicaid funded services otherwise. The state is requesting approval of this home and community services program to serve at any given time up to 105 adults with severe disabling mental illness and to do so in three geographical areas based on an urban core. Those areas are: 1) Yellowstone County area, inclusive of Big Horn, Carbon, Stillwater, and Sweet Grass counties; 2) Butte-Silver Bow County area, inclusive of Beaverhead, Deer Lodge, Granite, and Powell counties; and 3) Cascade County area, inclusive of Blaine, Chouteau, Glacier, Hill, Liberty, Pondera, Teton, and Toole counties.

The state expects that this program of services will significantly advance the state's efforts to more effectively and efficiently meet the needs of persons with severe disabling mental illness. The state hopes that this program will model positive changes and significantly advance systems change in the delivery of mental health services by the state.

The implementation of this set of proposed rules, with the resulting establishment of a service program focused on providing services to meet the needs of adults with severe disabling mental illness, is necessary to generally assure the well being of those persons who participate in the program. Adults with severe disabling mental illness are vulnerable to institutionalization. Their mental illness precludes self care in many respects and results in deteriorating physical health and further exacerbation of their mental illness. The provision of services to assist them in maintaining day to day health and personal care, living independently, and coping

with their mental illness can foster and maintain their ability to live in a community setting.

The department has considered maintaining the status quo as an alternative to this initiative. The status quo does not include, and due to funding sources, cannot include those services that can sustain a person by meeting daily living needs. Other alternatives could not be identified.

The state must submit a formal application for federal approval for the initiation of this proposed program. The department has been receiving technical assistance and guidance from the regional and national federal CMS officials. It is the intent of the state to initiate services in October of 2006. Currently, in accordance with Presidential Executive Order 13175, November 6, 2000, a review period has been afforded the tribal governments in Montana. The state expects to submit the plan to the reviewing federal officials after September 4, 2006. The proposed rule set will be formally filed for adoption with the Secretary of State upon approval of the home and community services plan by the federal reviewing authorities.

PROPOSED RULE I: HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: FEDERAL AUTHORITIZATION AND STATE ADMINISTRATION

Proposed Rule I states the federal authority governing federal approval for the implementation of the state's new program of Home and Community Services for Adults with Severe Disabling Mental Illness that is to be funded with Medicaid monies. The provision by a state of health care and health care related services funded with federally derived Medicaid monies necessitates conformance by the state with federal statutes, regulations, and policies that govern expenditures of those monies. This proposed rule is necessary to denote that authority. The option of not specifying the federal authority governing the program was not considered appropriate.

In addition, the proposed rule establishes the discretion of the department to manage the various aspects of the program in conformance with federal authority, the appropriated budget authority, and as otherwise determined appropriate by the department. This application of discretion to the program is necessary to assure continuing conformance with the governing federal authority so as to avoid withdrawal of federal approval for the program and to avoid federal recoupment for expenditures of federal monies inappropriately expended. Discretion is also necessary to assure that the program is managed within the programmatic and fiscal parameters and limitations that the Legislature may impose upon the department in the appropriation process. The necessity to conform with governing authority and fiscal dictates precludes consideration of other options.

The proposed rule denotes the geographical regions within which the program will make services available. The state is seeking to obtain a waiver of statewide coverage in its federal program approval. The program is proposed to be

implemented with a small total enrollment and in three geographical regions rather than on a statewide basis due to the lack of sufficient resources for statewide implementation. Consequently, the alternative of initiating the program on a broader or statewide basis was not considered.

PROPOSED RULE II: HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: SERVICES

The proposed rule would specify the array of services that is to be available through the state's new program of Home and Community Services for Adults with Severe Disabling Mental Illness. These are the services that the department may provide to persons who meet the criteria for the program as outlined in proposed RULE IV. Proposed RULE II outlines the criteria for the department to determine the particular services, inclusive of program and nonprogram services, necessary to meet the recipient's needs. Proposed RULE II also states the criteria for denying a service to a person.

The proposed rule, specifying the array of services available through the program, is necessary for the purposes of conforming administration of the program with the governing federal authority, in particular the plan for the program as approved by CMS. The specification of the array of services is necessary for recipients, advocates, and providers to be informed of the list of available program services.

The provisions providing that a recipient may have a service denied or terminated and specifying the criteria for denial or termination of a particular service are necessary to apprise recipients that receipt of particular services are subject to conditions and to provide notice of those qualifying conditions. Specification of the criteria is also necessary to provide conformance with the governing federal authority, in particular the plan for the program as approved by CMS.

The option of not outlining the services and the criteria for denying or terminating a program service was rejected, as it would leave the public without any guidance as to the array of services included in the program as well as the basis for denying a program service, and the department would lack express rule authority by which to appropriately regulate the use of particular services by recipients in accordance with governing authorities and the identified needs of the recipients.

The services selected to be offered as program services are those services that the department determined would be of positive consequence in meeting the health and health related needs of the service population, adults with severe disabling mental illness, and that are appropriate services to be delivered under the service criteria of the governing federal authorities. Most of these services were selected by reference to the existing program of home and community services for persons who are elderly or have a physical disability. That program of services is designed to meet many of the same needs for its service population that this proposed program is to make available to persons with severe disabling mental illness. Those services are well established, having been in place for many years, and therefore are well

established, having been in place for many years, and therefore are well known to the provider community and have established definitions and standards of reimbursement. This existing set of services provides the desirable array of services by which to meet the outstanding needs of the intended service population. Consequently, viable alternative sets of services were not identified as to be considered in the alternative.

In addition, two services designed to particularly need the daily support of persons with severe disabling mental illness are included among the proposed services. Those services are illness management and recovery services and the Wellness Recovery Action Plan. These services are model services that have been identified by the efficacious components in a service array for persons with severe disabling mental illness. Other alternatives for the purpose of these services were not identified.

PROPOSED RULE III: HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: PROVIDER REQUIREMENTS

The proposed rule would establish the general provider requirements for the program of Home and Community Services for Adults with Severe Disabling Mental Illness. The proposed requirements include enrollment as a Medicaid provider, compliance with Medicaid fiscal and quality assurance standards, existence as legal entity, appropriate insurance coverage, and conformance with facility and professional licensing standards. The proposed rule also precludes immediate family members from serving as a provider and allows for services to other family members if approved by the case management team. The proposed rule is necessary to establish that the services available through the program may only be provided by or through a provider that is enrolled as a Medicaid provider with the department, that meets all licensing and other nonprogrammatic requirements, that complies with the requirements related to the receipt of Medicaid monies, that meets the programmatic requirements governing the delivery of services, and that is not compensated for familial responsibilities. These provider requirements are necessary to provide conformance with the governing federal authority.

The option of not providing for provider selection by the program and compliance by the provider with governing authorities was rejected, as it would leave the public vulnerable to unqualified providers and the state vulnerable to the misappropriation of program funding.

PROPOSED RULE IV: HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: ELIGIBILITY AND SELECTION

The proposed rule states the eligibility criteria for acceptance into the program, the criteria for a person accepted into the program to be considered for a particular service opportunity that becomes available, the criteria by which among those

persons being considered for a service opportunity the person most suitable for the service opportunity is selected, and bases upon which a person may be removed from a service opportunity or the program. These features are necessary to assure that services are provided to persons who are appropriate for and in need of the services of the program and that the eligibility parameters of the plan entered into with CMS for the program are properly implemented and complied with. Of further importance is the necessity for the rules in order to fairly and appropriately assign the service opportunities of the program as among the persons determined to be eligible.

Service opportunities under federal law for Medicaid funded home and community services are not available on an unlimited basis. By agreement with the federal officials, a ceiling must be placed upon the service population for the program. The proposed rules are further necessary to assure that the number of service opportunities are rationed within the limits of the federal approval and state appropriations.

The program is to be available in three geographical regions of the state and there is funding for a total of 105 slots per year.

The option of not outlining the enrollment and disenrollment criteria was rejected, as the public, consumers, families, advocates, and program providers would be uninformed. In accordance with the federal authority for the program, it is necessary for the department to outline the enrollment and disenrollment criteria.

The department initiated the program for the purpose of addressing a significant need for health and health related services to maintain adults with severe disabling mental illness in community settings as opposed to more restrictive less integrated institutional settings. Consequently, consideration was not given to varying the principal definitional parameters for the eligibility criteria. That criteria referenced from an existing set of criteria established in departmental rule is based on national criteria for establishing the presence of severe mental illness. The definition of a service population is essential to federal approval of the program as a Medicaid funded home and community program. The federal authorities limit the potential service populations to persons who can meet standard Medicaid eligibility and who are within a well defined service population predicated upon one or more types of disability. The state may not vary from criteria once accepted by the approving federal authorities. Some of the proposed eligibility criteria, in particular that related to potential institutionalization, are necessarily drawn from the governing federal authority that commands such criteria.

The proposed criteria to govern termination of services were generally drawn from the established home and community services program for persons who are elderly or who have physical disabilities. The selection of that existing set of criteria was considered most appropriate in that there will be significant similarities in the delivery of this program’s services to delivery of services to that program’s service population. The criteria of that program for purposes of termination has been drawn

from over 20 years of experience in eligibility matters and service delivery.

PROPOSED RULE V: HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: REIMBURSEMENT

The proposed rule would establish how the services available in the program will be reimbursed. That proposed rule groups lists of services by each type of reimbursement methodology and describes the reimbursement methodologies. The proposed rule also states that reimbursement is not available for services that may be reimbursed through another program, that there is no copayment cost sharing requirement for program services, and that there is no reimbursement for the provision of program services to other members of a recipient's household or family unless specifically provided for in these rules.

The option of not stating the reimbursement practices of the department was rejected, as clarity of reimbursement is essential for the fiscal management of the program.

The methodologies for reimbursement of services provided through the Home and Community Services Program for Adults with Severe Disabling Mental Illness are those currently applied to the state's program of home and community services for persons who are elderly or who have physical disabilities. This set of methodologies is being selected over other possible methodologies because it is a well established set of methodologies that is being applied to an existing program that has close parallels to this program. Furthermore, the providers of services for this waiver program may be the same providers for the elderly and physically disabled. Implementation of this set of methodologies for the department and the providers will be facilitated by the use of the same set.

As a further measure to facilitate implementation and to provide conformity, those program services that are the same as any of the services currently available as so-called "state plan" Medicaid services, inclusive of personal assistance, outpatient occupational therapy, and the various mental health services, are to be reimbursed in the same manner as the state plan services.

Other approaches to reimbursement for these services were not considered since there are significant advantages, administratively and in provider relations, to replicating the reimbursement methodologies for the long established state plan services and for the services of the elderly and disabled home and community program.

PROPOSED RULE VI: HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: PLANS OF CARE

The proposed rule would require the development of plans of care for recipients of Home and Community Services for Adults with Severe Disabling Mental Illness. The particular types of services that may be provided to a recipient, along with the

specifics of hours of delivery, choices of providers, and unique aspects of delivery for a recipient, are set forth in the plan of care. The proposed rule also establishes the process for development of a plan of care, provides that the case management team is responsible for the plan of care, and denotes the intervals for which plans of care are initially developed and subsequently reviewed.

The proposed rule is necessary to assure the appropriate planning for an implementation of service provision to persons eligible for the program. The delivery of services to a person will be ineffective unless the planning, development, and delivery of services is done in a manner that matches those services to the person's needs and assures that they are effectively delivered and monitored. The plan of care serves that purpose.

The plan of care requirements assure that there is consistent implementation within the state of services for recipients. Federal guidelines for the state include the requirement for individual plans of care for program enrollees to address needs and outline services appropriate to meet those needs. The department must comply with and cannot vary from the federal guidelines in order to receive approval and funding for the program.

The option of not implementing the plan of care and not defining the components of a plan of care, the responsible parties for a plan of care, and the file retention practices was rejected. In the absence of the plan of care, the program would not effectively deliver services. The department did not find any alternative structures and processes to that of the plan of care.

PROPOSED RULE VII: HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: COST OF PLANS OF CARE

The proposed rule would govern the total costs of each plan of care for services provided to each recipient of Home and Community Services for Adults with Severe Disabling Mental Illness. The proposed rule provides that the annual cost of services for each enrollee is limited, unless expressly waived by the department, to a maximum amount calculated based upon the number of permissible enrollees and the amount of monies available to the program as authorized in appropriations by the legislature. The amount is also limited in that the cost of program services for all eligible persons in the aggregate cannot exceed what it would cost to provide services in a nursing facility for those persons. The proposed rule lists certain types of circumstances, temporary or extended, for which a plan of care for a program enrollee may exceed the maximum amount set by the department. These fiscal limitations are necessary to assure that the state may fiscally manage the program within the legislative appropriation available for the program and within the restrictions imposed by the governing federal authorities and in turn to apprise recipients, providers, and others of those fiscal limitations.

The option of not proposing the rule was not considered since financial restrictions

upon the expenditures for the program are state and federal law legal obligations. In addition, the public, consumers, families, and program providers would not be aware of the financial limitation imposed upon the department in the administration of the program. Other forms of restrictive financial limitation were not considered since the provision of services is desirable and the proposed restrictions were appropriate to meet fiscal and legal requirements.

PROPOSED RULE VIII: HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: NOTICE AND FAIR HEARING

The proposed rule would establish the due process that would be available to recipients who wish to contest an adverse programmatic decision through reference to existing rules for fair hearings and adverse actions that would be appropriately applicable to this program. This proposed rule is necessary to assure conformity with due process requirements established in laws applicable to the program.

The department did not consider foregoing the adoption of this rule because of the necessity under federal law of providing due process fair hearings for persons who may be aggrieved by departmental actions concerning their eligibility and benefits. Under federal authority, the due process to be accorded must be in the form of a fair hearing. Consequently, the department did not consider any alternative due process forums or procedures.

PROPOSED RULE IX: HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: CASE MANAGEMENT, REQUIREMENTS

This proposed rule sets forth the purpose of, tasks of, composition of, and certain provider requirements peculiar to case management teams. The proposed rule is necessary in that the establishment of case management teams is vital to the delivery of the services of a program of home and community services. The teams are to effectuate the plans of care.

Recipients will benefit in that their service needs in conjunction with the recipients are professionally determined and service delivery is managed to assure effective competent delivery and service adjustments as needed.

The department selected the proposed case management tasks because they are the tasks that are currently applicable to the case management teams serving the recipients in the home and community services program for the elderly and persons with disabilities. These tasks, due to their universality in assuring the delivery of services, also typically appear in other case management services of the department.

The proposed professionals to be designated members of the case management team, the registered nurse experienced in the delivery of services for the program for

the elderly and persons with physical disabilities, and the social worker with experience in mental health services, were chosen because there is the need to utilize in case management services those professionals who are experienced either in the service modality of home and community services or in the management of treatment for persons with mental illness. Other types of professionals and other professional configurations were considered but did not offer the advantages of the chosen types and configuration and would not be as capable of immediate delivery of services in the initial phase of startup.

PROPOSED RULES X THROUGH XXVIII

Proposed Rules X through XXVIII specify the requirements for the various specific services that may be obtained and paid for through the adult with severe disabling mental illness program. Those services as specified in proposed Rule II include adult residential care services, supported living services, adult day health services, personal assistance services, habilitation services, specially trained attendant care services, homemaking services, respite care services, outpatient occupational therapy services, psycho-social consultation services, chemical dependency counseling services, dietetic services, nutrition services, nursing services, personal emergency response systems services, specialized medical equipments and supplies services, illness management and recovery services, Wellness Recovery Action Plan services, and nonmedical transportation services. These services have been selected as described in the discussion of proposed Rule II.

The various requirements pertaining to the proposed services have been drawn directly from the requirements applicable to those services currently as provided in the context of the program of home and community services for persons who are elderly or who have physical disabilities. As noted in the discussion of proposed Rule II, this set of services is well established in the context of that other program. Consequently, uniformity of requirements among the two programs is appropriate for purposes of administrative convenience and provider performance and compliance. Other sets of requirements were not considered appropriate given the desirability of uniformity.

4. Interested persons may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210, no later than 5:00 p.m. on September 21, 2006. Data, views, or arguments may also be submitted by facsimile (406)444-1970 or by electronic mail via the Internet to dphhslegal@mt.gov. The department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

5. The Office of Legal Affairs, Department of Public Health and Human Services, has been designated to preside over and conduct the hearing.

/s/ Cary Lund
Rule Reviewer

/s/ Russell Cater for
Director, Public Health and
Human Services

Certified to the Secretary of State August 14, 2006.